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IN THE
Supreme Court of the United States

DAVID KING, *et al.*

Petitioners,

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

BRIEF OF HCA INC. AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS AND AFFIRMANCE

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

INTEREST OF AMICUS CURIAE 1

INTRODUCTION AND SUMMARY OF ARGUMENT 2

ARGUMENT 5

I. HCA's Data Show That The ACA Is Functioning As Intended. 5

A. Patients Are Taking Greater Personal Responsibility For Their Health Care Costs. 7

B. HCA's Exchange Patients Use Emergency Rooms At Dramatically Reduced Rates, And Have Better Access To Outpatient Services. 10

C. Women Comprise Two-Thirds Of HCA Patients On The Exchanges And Receive Care That Might Otherwise Be Unavailable To Them. . 14

D. A Substantial Share Of HCA's Patients On The Exchanges Were Previously Insured, And Would Be At Risk Of Becoming Uninsured If Petitioners Prevail. 18

E. The ACA's "Shared Responsibility" Framework Is Functioning As Congress Intended. 23

II. The ACA Provides Subsidies To Residents Of States That Elect Not To Administer An Exchange. 28

A. Petitioners' Interpretation Is Inconsistent With The Statutory Text. 28

B. Petitioners' Interpretation Is Inconsistent With The Statutory Structure. 31

C. Petitioners' Interpretation Is Inconsistent With The Statutory Purpose. 35

D. Petitioners' Interpretation Yields Absurd Consequences. 36

CONCLUSION 39

TABLE OF AUTHORITIES

Page(s)

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529 U.S. 120 (2000) 31, 33

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490 U.S. 504 (1989) 36–37

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134 S. Ct. 1158 (2014) 37

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133 S. Ct. 2191 (2013) 30, 35

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134 S. Ct. 1422 (2014) 37

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557 U.S. 193 (2009) 31

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491 U.S. 440 (1989) 37

Whitman v. Am. Trucking Ass'ns,
531 U.S. 457 (2001) 29

Statutes

Patient Protection and Affordable Care Act of
2010 ..... *passim*

tit. I, subtit. F, pt. I 9

tit. I, subtit. E 28, 35

§ 2551 24

§ 3025 24

§ 3133 24

§ 3401 24

26 U.S.C.

§ 36B ..... *passim*

§ 5000A 9, 20

42 U.S.C.

§ 256a–1 13

§ 300gg 17, 22

§ 300gg–1 22

§ 300gg–3 22

§ 300gg–6 22

§ 300gg–13 ..... 13, 17

§ 300gg–17 13

§ 300gg–18 33

§ 300gg–19a 18

§ 300gg–91 29

§ 1395cc–5 13

§ 1395dd 16

§ 1396a 17

§ 18011 21

§ 18022 ..... 13, 17, 22

§ 18031 ..... 29, 30

§ 18032 30

§ 18041 ..... 30, 34

§ 18061 33

§ 18071 9

§ 18091 ..... 9, 13, 23, 35

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INTEREST OF AMICUS CURIAE

HCA Inc. (together with its affiliates, "HCA"), also known as Hospital Corporation of America, is the nation's largest non-governmental health care provider.[1] In the United States, HCA owns and operates 155 acute care hospitals, 112 ambulatory surgery centers, and 3 psychiatric facilities. In 2014, HCA facilities, together with its 37,000 affiliated medical staff physicians, 75,000 nurses, and 220,000 total employees, provided care to patients in connection with approximately 7.5 million emergency room ("ER") visits, 1.4 million surgeries, and 1.8 million inpatient admissions.

HCA is significantly affected by the Patient Protection and Affordable Care Act of 2010 ("ACA"). More than 88% of HCA's facilities are located in a state in which the federal government operates the American Health Benefit Exchange ("Exchange") for that state's residents. In three of these states – Florida, Texas, and Virginia – HCA owns and operates approximately one out of every five licensed hospital beds.

HCA maintains extensive aggregate information about the care it delivers, including care

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[1] Pursuant to Rule 37.6, *amicus* affirms that no counsel for a party authored this brief in whole or in part and that no person other than *amicus* or its counsel made any monetary contribution intended to fund the preparation or submission of this brief. Pursuant to this Court's Rule 37.3(a), letters from all parties consenting to the filing of this brief have been submitted to the Clerk.

to patients enrolled on the federally-facilitated Exchanges. HCA believes that its detailed data, current through the year ending December 31, 2014, could assist the Court in understanding the on-the-ground operation of the ACA, and inform the Court's interpretation of the statutory provisions at issue in this case. While HCA's database is limited to the patients who visit its facilities, it provides data of a kind that has not been publicly available, and sheds light on the experiences of a substantial group of patients. HCA has published an analysis of this data, which forms the basis of the material presented in this brief. *See* HCA, *Analysis of HCA Data Relevant to Aspects of the Affordable Care Act* ("HCA Report") (Jan. 2015), *available at* http://www.hcahealthcare.com/util/documents/hca-data-aca.pdf.

INTRODUCTION AND SUMMARY OF ARGUMENT

The availability of subsidized coverage in states with federally-facilitated Exchanges is a critical component of the ACA's statutory structure. Without these subsidies, important provisions of the statute would make little sense, and Congress's basic objectives would be thwarted. In this brief, HCA demonstrates, through its internal data, that the fundamentally interdependent provisions of the ACA are functioning as Congress intended. It also shows that Congress's intentions will be compromised if the subsidies are invalidated.

1. There has been significant public focus on the enrollment figures for the ACA Exchanges. Much less is known, however, about enrolled

individuals as *patients* seeking care. HCA's data provide useful information about these Exchange patients and the functioning of the Exchanges in several respects:

Personal Responsibility: Nine out of ten uninsured HCA patients pay nothing to HCA or its affiliates for the care they receive. HCA Report at 6. By contrast, HCA's patients on the federally-facilitated Exchanges who make cost-sharing expenditures pay on average $390 out-of-pocket per visit for care at HCA facilities. *Id.* at 7. Thus, the availability of subsidized coverage is achieving the congressional objective of promoting personal responsibility.

Encouraging Care in Appropriate Settings: Consistent with these changes, uninsured patients are approximately three times more likely to seek care in the ER than are patients on the federally-facilitated Exchanges. HCA Report at 8. Similarly, Exchange patients are more likely than uninsured patients to receive medically necessary non-ER outpatient care. *Id.* These significant differences show that the ACA is achieving Congress's goals of reducing ER use and causing patients more often to use the most appropriate care setting for their conditions.

Access to Needed Care for Women: Fifty-three percent of HCA's uninsured patients are women. That percentage spikes dramatically to 65% in the federally-facilitated Exchange population. HCA Report at 5. Women with such Exchange coverage who seek care at HCA facilities receive medically necessary, non-ER outpatient services, such as ultrasounds, at higher rates than uninsured women.

Id. at 11. Congress was acutely concerned with the health issues faced by women, and the particular difficulties many women had in obtaining adequate and affordable coverage. HCA's data indicate that many female patients who have moved from being uninsured to insured through the Exchanges are better able to access medically necessary care.

The Previously Insured: Among HCA's patients on the federally-facilitated Exchanges that it had treated before, a majority were previously insured. HCA Report at 5. Paradoxically, if subsidies are eliminated, this large group of previously insured Exchange enrollees would find it *more* difficult to purchase affordable coverage than before the ACA.

"Shared Responsibility": HCA's data illustrate not just how the ACA is operating for patients, but also how it is affecting hospitals and other providers. HCA has already incurred hundreds of millions of dollars in Medicare reimbursement cuts under the ACA. HCA Report at 12. However, expanded insurance on the Exchanges is beginning to offset these costs with new revenues. *Id.* This was exactly what Congress intended when it sought to have every stakeholder in the health care system share the costs and benefits of achieving universal coverage. This "shared responsibility" framework would be disrupted if subsidies were eliminated and the expansion of insurance in the federally-facilitated Exchange states were reversed.

2. Every tool of statutory construction confirms that the radical change in the operation of the statute urged by Petitioners is unwarranted. Congress did not, in a provision for calculating the

amount of a taxpayer's subsidy, hide a device for making coverage unaffordable for millions of Americans. Instead, the statutory text demonstrates that Congress used the term "Exchange established by the state" as a term of art that encompasses federally-facilitated Exchanges. As HCA's data help demonstrate, Petitioners' contrary interpretation would disrupt critical aspects of the statutory structure and thwart fundamental purposes of the ACA. In fact, the consequences of Petitioners' interpretation are so absurd that Congress could not possibly have intended them.

ARGUMENT

I. HCA's Data Show That The ACA Is Functioning As Intended.

The ACA's provisions are fundamentally "interdependent." *Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), 132 S. Ct. 2566, 2670 (2012) (Scalia, Kennedy, Thomas & Alito, JJ., dissenting). HCA's data show these interdependencies at work, demonstrating that – in large part because subsidies are available on the federally-facilitated Exchanges – the statute is operating as Congress intended:

- Congress designed the ACA so that individuals who previously did not pay for care would take personal financial responsibility for that care. HCA's data reveal that patients on the federally-facilitated Exchanges, unlike uninsured patients, make significant contributions to the cost of their treatment.
- Congress sought to reduce ER usage by the uninsured and to encourage patients to use

more efficient forms of care. HCA's data show that patients on the federally-facilitated Exchanges are using emergency rooms significantly less than uninsured patients.

- Congress intended to redress particular challenges faced by women in obtaining affordable insurance and accessing needed care. HCA's data indicate that women are now benefitting from the availability of Exchange coverage and have improved access to needed diagnostic care and treatments.

- Congress focused not just on securing coverage for the uninsured, but also on improving coverage for the previously insured. Of patients with federally-facilitated Exchange coverage for whom HCA has data, a majority previously had insurance. This population would find it *substantially more* difficult than before the ACA to obtain coverage if the subsidies are eliminated.

- The ACA embodied a carefully-constructed "shared responsibility" framework under which health care providers would shoulder some of the costs but also share in some of the benefits. HCA's data show that hospitals have taken significant cuts in federal reimbursements under the ACA, but that these cuts are beginning to be offset by new revenues from expanded Exchange insurance.

Together, HCA's data illuminate the basic structural issue in this case. Interpreted to make subsidies available on the federally-facilitated Exchanges, the ACA functions as a coherent whole

and achieves Congress's goals. Interpreted to withhold subsidies from individuals in states with federally-facilitated Exchanges, the law comes apart at the seams, jeopardizing important achievements and leading to consequences Congress could not possibly have intended.

A. Patients Are Taking Greater Personal Responsibility For Their Health Care Costs.

One of the problems Congress sought to address in the ACA was the reality that individuals who were not able to purchase insurance often became "free riders," accessing care in emergency rooms that they cannot and do not pay for. The costs of this "uncompensated care" were passed on throughout the economy. HCA's data indicate that subsidized coverage on the federally-facilitated Exchanges diminishes the free-rider problem and increases the percentage of people who take personal responsibility for their health care choices.

In 2014, 89.6% of HCA's uninsured patients paid nothing for the health care services provided by HCA's facilities. HCA Report at 6. The percentage paying $0 remains virtually unchanged even if the calculation considers only uninsured individuals with incomes above 200% of the federal poverty level (under its charity care policy, HCA does not charge uninsured patients whose incomes are at or below 200% of the poverty line). *Id.*

By contrast, in a majority of cases, HCA patients who are enrolled in a federally-facilitated Exchange pay their cost-sharing obligations. While

insurers are required to provide free preventive services (*e.g.*, cancer screenings), Exchange plans often require patients to pay sizable deductibles, co-payments, and co-insurance, even for ER visits. HCA's patients on the federally-facilitated Exchanges who make these cost-sharing expenditures pay on average $390 out-of-pocket for care at HCA facilities. HCA Report at 7.

This level of cost-sharing may be significant for many Exchange patients. Nationally, approximately 87% of Exchange enrollees qualify for subsidies.[2] For example, an individual making $29,300 per year, or just over 250% of the 2014 federal poverty level for a single person, would qualify for subsidized premiums through an Exchange (but not cost-sharing subsidies). Thus, for a visit to HCA facilities (such as an ER or inpatient visit), she could spend $390 – representing 16% of her pre-tax monthly income.

Congress concluded that individuals should pay for a share of their health costs in this way. Doing so was a way to promote personal responsibility, smarter health care choices, and the use of less expensive modes of care.

Fostering personal responsibility and reducing uncompensated care were basic goals of the ACA.

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[2] Office of Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health and Human Servs., *ASPE Issue Brief, Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report* 7–8, 14, 24 (Dec. 30, 2014), *available at* http://tinyurl.com/pzterwl.

Congress called the individual mandate penalty a "[s]hared responsibility payment," 26 U.S.C. § 5000A(b), and located it in the part of the Act entitled "Individual Responsibility." ACA tit. I, subtit. F, pt. I. An express statutory reason for pursuing near-universal coverage was to reduce the $43 billion (as of 2008) in annual uncompensated care that the uninsured passed on to insured families. 42 U.S.C. § 18091(2)(F); *NFIB*, 132 S. Ct. at 2585 (op. of Roberts, C.J.). Members of Congress further explained that the ACA was intended to "promote personal responsibility," 155 Cong. Rec. 23,370 (Oct. 1, 2009) (Sen. Mark Begich), and reduce the shifting of uncompensated care costs. *See* 156 Cong. Rec. H1801 (daily ed. Mar. 20, 2010) (Rep. Tim Ryan) ("[I]t is cheaper for us as a country, since we are all already paying for [the uninsured] anyway through higher insurance premiums, it is cheaper for everybody if we give them an insurance card and make them pay something. No more free riders. Everyone is going to have to pay something.").

In designing the subsidies themselves, Congress was similarly attuned to the importance of individuals maintaining a personal stake in their care. Thus, Congress included income-based caps on the premium subsidies available to low-income individuals. 26 U.S.C. §§ 36B(b)(2), (b)(3)(A)(i). Moreover, for even the lowest income individuals eligible for subsidies, cost-sharing assistance was designed so that it would not completely eliminate an enrollee's obligation to share in the total cost of care through co-payments and deductibles. 42 U.S.C. § 18071(c).

Based on a full year of HCA's data for 2014, subsidized coverage on the Exchanges causes individuals and families to take personal responsibility for their care. Once they gain Exchange coverage, they pay a meaningful amount out of their own pockets, and they avoid generating uncompensated costs that are paid for by businesses and individuals throughout the economy. If the subsidies are invalidated for the federally-facilitated Exchanges, many individuals on those Exchanges (including those who were previously insured, *see infra* pp. 18–23) will likely lose coverage and no longer take personal financial responsibility for their care.

In sum, numerous statutory provisions and the overall statutory structure confirm that Congress wanted individuals who receive care to have a financial stake in, and share responsibility for, the care they receive. Petitioners' interpretation would take that away.

B. HCA's Exchange Patients Use Emergency Rooms At Dramatically Reduced Rates, And Have Better Access To Outpatient Services.

Congress intended the ACA to tackle the problem of ER use by the uninsured for non-emergency health care issues. HCA's data show that the ACA has in fact measurably reduced ER visits for the newly insured, and has likewise increased the use of non-ER, medically necessary outpatient services.

In order to assess the ACA's effects on ER usage, HCA measured the ratio of ER visits to inpatient admissions.[3] HCA Report at 8. In 2014, uninsured patients visited the ER approximately ten times for every inpatient admission. *Id.* By contrast, individuals insured through the federally-facilitated Exchanges are visiting the ER approximately three times for every inpatient admission. *Id.* Thus, HCA's data indicate that uninsured patients are about 300% more likely than Exchange patients to rely on ER care.

Apart from ER usage, HCA has also measured improved access to needed outpatient services, again using inpatient admissions as a control. These data similarly suggest that the ACA is having its intended effect. In 2014, uninsured individuals made non-ER outpatient visits to HCA facilities approximately 1.4 times for every inpatient admission. HCA Report at 8. By contrast, individuals insured through the federally-facilitated Exchanges are making outpatient visits to HCA facilities 2.8 times for every inpatient admission. *Id.* HCA's data reflect that the likelihood that an individual will access outpatient care nearly doubles when he or she has coverage through a federally-facilitated Exchange.

Thus, at the same time that Exchange patients are relying less on the ER, they are

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[3] Because inpatient admissions are typically unavoidable, the insured and uninsured tend to be admitted for inpatient services at a similar rate. This makes inpatient admissions a useful "control" against which to compare ER use and outpatient visits.

receiving more outpatient care than the uninsured, including care (such as chemotherapy) that is typically unavailable in the ER. That care is being provided in more appropriate and cost-effective settings.

This striking reduction of ER usage and expansion of outpatient care in HCA facilities is a predictable result of affordable coverage through subsidized insurance on the Exchanges. Patients without coverage may wait until they are seriously ill to seek care because they cannot afford to pay for primary care[4]; when they do fall ill, they typically turn to the ER, where most uninsured individuals pay nothing. *Supra* p. 7. Patients on the federally-facilitated Exchanges, by contrast, take responsibility for a share of their costs, *supra* pp. 7–8, and so have both the ability and a financial incentive to seek timely and medically necessary outpatient care, and to avoid ER visits for care which could be provided in a more efficient setting.

These changes in the way patients are accessing care were core objectives of the ACA. Overuse of emergency rooms and delayed access to appropriate care were symptoms of the problem of the uninsured: as Congress expressly found, "[t]he cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008," which

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[4] *See, e.g.*, Nat'l Ctr. for Health Statistics, U.S. Dep't Health and Human Servs., *Health, United States, 2012*, at 235 tbl. 73 (May 2013), *available at* http://tinyurl.com/o5h6e22 (as of 2011, 35% of uninsured did not seek or delayed medical care due to cost compared with 7.4% of privately insured).

"increas[ed] family premiums by on average over $1,000 a year." 42 U.S.C. § 18091(2)(F). Indeed, the goal of limiting ER usage in favor of more efficient forms of care is manifest throughout the ACA.[5]

Members of Congress echoed this central goal of "preventing [the uninsured] from depending on expensive emergency services in place of regular health care." 155 Cong. Rec. 33,024 (Dec. 22, 2009) (Sen. Patrick Leahy). The pre-ACA increase in the number of Americans who were "not . . . able to afford insurance" meant they were "going to show up at hospital emergency rooms," which "costs a lot." 155 Cong. Rec. 29,762 (Dec. 8, 2009) (Sen. Barbara Boxer); *see also* 156 Cong. Rec. H1801 (daily ed. Mar. 20, 2010) (Rep. Tim Ryan) ("[W]e have 30 million-plus people in the United States of America who have no preventive care at all, dumped into our emergency rooms, much sicker than they need to be."). Members of Congress emphasized the importance of patients receiving non-emergency care in the most appropriate setting so that they could

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[5] *See* 42 U.S.C. § 18022(b)(1)(I) (requiring coverage for "[p]reventive and wellness services and chronic disease management" as an Essential Health Benefit); *id.* § 300gg–13(a) (requiring plans to cover certain preventive health services free of cost-sharing); *id.* § 300gg–17(a) (requiring the development of health plan reporting requirements related to care coordination, disease management, medical homes, and preventing hospital readmissions); *id.* § 1395cc–5(a) (requiring the Secretary to test an outcome-based health care delivery model to be judged, *inter alia*, on its success in "reducing emergency room visits"); *id.* § 256a–1 (requiring the Secretary to establish "community health teams" that, *inter alia*, ensure "access to the continuum of health care services in the most appropriate setting").

avoid more expensive emergency and inpatient care. *See* 155 Cong. Rec. 23,038 (Sept. 30, 2009) (Rep. Jason Altmire) ("[W]e need to get [people] their health care in the most appropriate, cost-efficient setting . . . .").

HCA's experience shows that subsidized coverage on the federally-facilitated Exchanges is having its intended effect of reducing ER usage and encouraging greater use of medically necessary outpatient care. The likely effect of stripping the subsidies is that many Exchange enrollees will join the ranks of the uninsured and revert to the patterns of ER use that Congress sought to counteract. In fact, as discussed below, many individuals on the Exchanges who *were* previously insured would likely lose access to affordable coverage as a result of Petitioners' interpretation. *See infra* pp. 18–23. Petitioners' construction would thus not only frustrate the legislative aim of reducing ER usage and promoting use of more appropriate forms of care, it would actually make matters worse than they were before the ACA. This could not have been Congress's intent, given its express goal of reducing the delivery of uncompensated care and driving non-emergency care out of the ER.

C. Women Comprise Two-Thirds Of HCA Patients On The Exchanges And Receive Care That Might Otherwise Be Unavailable To Them.

Another core pillar of the ACA was Congress's goal of ensuring that women are able to meet their health care needs. Based on HCA's data, those needs

are being met far more than they were prior to the ACA's enactment.

Among the uninsured, 53% of HCA's patients are women. HCA Report at 5. On the federally-facilitated Exchanges, by contrast, 65% of HCA's patients are women, outnumbering men nearly two to one. *Id.*

Women enrolled on the federally-facilitated Exchanges access care in greater numbers in part because in the relevant age range – up to 65 – women are at greater risk for certain health issues.[6] Consistent with this fact, HCA's data show that a remarkable 77% of the oncology care given to federally-facilitated Exchange patients at HCA facilities is for women. HCA Report at 10.

Ultrasounds provide an illustration of how women with federally-facilitated Exchange coverage are better able to access needed health services. If a woman has a breast lump or mass or an abnormal mammogram, it is common for a physician to order an ultrasound to determine if it is a benign cyst or a

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[6] For example, in 2013, cancer was the leading cause of death among women in the 35–54 age group, with breast cancer accounting for the largest number of cancer deaths; there are also approximately 2.9 million breast cancer survivors in the United States. *See* Ctrs. for Disease Control and Prevention, Nat'l Ctr. for Health Statistics, *Underlying Cause of Death 1999–2013*, on CDC WONDER Online Database, *available at* http://tinyurl.com/ma8w85l; Am. Cancer Soc'y, *What are the key statistics about breast cancer?*, http://tinyurl.com/32e6vej (last revised Dec. 31, 2014).

malignancy.[7] These breast ultrasounds are not, however, usually available in an ER, the primary site of care for many uninsured women. The result: HCA's patients enrolled in the federally-facilitated Exchanges are over *three times* more likely to obtain an ultrasound for a breast lump, mass, or abnormal mammogram than a woman who is uninsured. HCA Report at 11. This improved access to an important diagnostic tool for patients at risk for breast cancer would likely be reversed if subsidies are eliminated.

Without access to affordable coverage, patients will also face reduced access to treatment options for chronic conditions, such as cancer. Under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals must provide stabilizing treatment for "emergency" medical conditions, but not non-emergency care, such as chemotherapy and radiation.[8] Although Medicaid may provide some coverage for women diagnosed with breast or cervical cancer, such coverage varies by state, and is limited to women screened and diagnosed through certain programs for low-income individuals for which many

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[7] Johns Hopkins Medicine, *Breast Ultrasound*, http://tinyurl.com/mkvfg2s (last visited Jan. 22, 2015); *see also* Am. Coll. of Radiology, *ACR Practice Parameter for the Performance of a Breast Ultrasound Examination* 1–2 (amended 2014, Resolution 39), *available at* http://tinyurl.com/meswwoe; Regina J. Hooley et al., *Breast Ultrasonography: State of the Art*, 268 Radiology 642, 643 (Sept. 2013) ("Ultrasonography has become an indispensable tool in breast imaging.").

[8] 42 U.S.C. § 1395dd; *see also* Aaron Carroll, *Why emergency rooms don't close the health care gap*, CNN, May 7, 2012, http://tinyurl.com/p6wqd3t.

current Exchange enrollees will not qualify. *See* 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII); *id.* § 1396a(aa). Without coverage, some patients may turn to public hospitals, but capacity at these institutions may be strained and there may be long waits for appointments.[9] As a result, the elimination of subsidies would adversely affect patients – and especially women – who require treatment for life-threatening diseases like cancer.

Congress was acutely concerned with the health care needs of women in enacting the ACA. For example, the ACA bans gender-based rate discrimination that made quality coverage less affordable for women. 42 U.S.C. § 300gg. In requiring health plans to cover all "Essential Health Benefits," Congress directed HHS to "take into account the health care needs of diverse segments of the population, including women." *Id.* § 18022(b)(4)(C). Moreover, Congress required health plans to make numerous preventive services available for free, specifically mentioning the preventive care needs of women. *Id.* § 300gg–13(a)(1), (4).[10] Similarly, Congress prohibited health

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[9] Laurie E. Felland & Lucy Stark, *Local Public Hospitals: Changing with the Times*, Ctr. for Studying Health Sys. Change, Research Brief No. 25, at 1–2 (Nov. 2012), *available at* http://tinyurl.com/pll4n7y (citing "inadequate capacity" and "long waits").

[10] *See also* HealthCare.gov, *Preventive health services for women*, http://tinyurl.com/n5jp4z8 (last visited Jan. 23, 2015) (listing 22 preventive health services for women that plans must offer without cost-sharing).

plans from requiring prior authorizations or referrals for in-network obstetrical or gynecological care. *Id.* § 300gg–19a(d)(1).

HCA's data reveal that women make up nearly two-thirds of its federally-facilitated Exchange patients, a substantial increase from the uninsured population. The data show, moreover, that this Exchange coverage is enabling better access to needed care. Congress could not have intended the achievement of this important objective to be unraveled in states that elect not to administer their own Exchanges.

D. A Substantial Share Of HCA's Patients On The Exchanges Were Previously Insured, And Would Be At Risk Of Becoming Uninsured If Petitioners Prevail.

The ACA sought to improve access to quality, affordable health coverage, not only for the uninsured population but also for those who previously had insurance. Previously uninsured individuals, for whom the ACA's subsidies now make insurance affordable, have been an understandable focus of this case. However, the stakes may be just as high for the many Americans now insured on the Exchanges who had coverage prior to enactment of the ACA. Absent functioning Exchanges with subsidized coverage available, the ACA could have the paradoxical effect of making it more difficult for these individuals to obtain insurance.

The previously insured account for a majority of HCA Exchange patients for whom relevant data

are available. In 2014, approximately 51,000 of HCA's patients on the federally-facilitated Exchanges had previously been provided care by HCA. HCA Report at 5. Of that group, 56% were insured at the time of their prior treatment. *Id.* This is consistent with national surveys concluding that between 37% and two-thirds of all Exchange enrollees were previously insured.[11]

This large group of previously insured Americans will face an extremely difficult situation if subsidies are eliminated. While they could retain their coverage at an "unsubsidized" rate, many if not most will find that insurance unaffordable. For example, a waitress in Jacksonville, Florida has a mean annual income of $21,230 (including tips), or 182% of the federal poverty level for a single person

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[11] *See* Press Release, *New Survey: After First ACA Enrollment Period, Uninsured Rate Dropped from 20 Percent to 15 Percent; Largest Declines Among Young Adults, Latinos, and Low-Income People*, The Commonwealth Fund (July 10, 2014), *available at* http://tinyurl.com/k4xuyd2 (37% of Exchange enrollees previously insured); Liz Hamel et al., *Survey of Non-Group Health Insurance Enrollees*, Henry J. Kaiser Family Found. (June 19, 2014), http://tinyurl.com/q6wc56r (43% of Exchange enrollees previously insured); Katherine Grace Carman & Christine Eibner, *Survey Estimates Net Gain of 9.3 Million American Adults with Health Insurance*, RAND Corp. (Apr. 8, 2014), http://tinyurl.com/lwo2dze (two-thirds of Exchange enrollees previously insured); *see also* Amit Bhardwaj et al., *Individual market: Insights into consumer behavior at the end of open enrollment*, McKinsey & Co. (May 8, 2014), http://tinyurl.com/q366knz (three-quarters of individual market enrollees previously insured, but data not limited to Exchanges).

(the national median, $18,590, is even lower).[12] Currently, she can obtain a "silver" plan on the state's federally-facilitated Exchange, with premium subsidies and cost-sharing assistance, for $96 per month (with a $1,450 deductible) or $115 per month (with no deductible). However, *unsubsidized* coverage under the least expensive "bronze" plan would cost her $198 per month – more than 11% of her pre-tax income – *and* she would be responsible for a $6,300 deductible.[13] This is not affordable coverage. *Cf.* 26 U.S.C. § 5000A(e)(1) (classifying an individual for whom coverage costs more than 8% of income as one who "cannot afford coverage").

In these circumstances, the healthy may leave the insurance market, which could result in adverse selection and an eventual "death spiral." Two recent studies suggest that the elimination of subsidies will cause premiums to rise by at least *35 to 43.3 percent*, respectively.[14] These studies predict that enrollment

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[12] *See* Bureau of Labor Statistics, *Occupational Employment and Wages, May 2013: 35-3031 Waiters and Waitresses*, *available at* http://tinyurl.com/om8t6gf (last modified Apr. 1, 2014).

[13] All of the figures in this paragraph are based on searches of HealthCare.gov conducted on January 14, 2015, for a 35-year-old, non-smoking applicant. These numbers, of course, reflect current market conditions, in which there is a diverse risk pool. Without subsidies, actual premiums would likely be higher as a result of adverse selection.

[14] Linda J. Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums* 6–7 & fig.1, Urban Institute (2015), *available at* http://tinyurl.com/lcwe5tl [hereinafter Urban Analysis]; Christine Eibner & Evan Saltzman, *Assessing Alternative Modifications to the Affordable* (continued...)

in ACA-compliant individual market plans would fall by *68 to 69 percent*,[15] and that the number of uninsured would increase by 8.2 million in states with federally-facilitated Exchanges.[16] "An ACA-compliant market without premium tax credits would consist of a relatively small number of high-risk individuals, preventing the majority of potential enrollees from purchasing affordable coverage."[17]

The previously insured would fare no better in the off-Exchange individual market. They might seek out "catastrophic coverage" plans, but even these must comply with the ACA's requirements, and as a result are unlikely to be much more affordable than a bronze plan. Transitional and grandfathered plans may be somewhat less expensive, but are not open to new enrollment, and therefore are unavailable to those presently insured on the Exchanges.[18] Moreover, those currently in transitional plans must exit those plans by September 2017,[19] forcing numerous currently

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Care Act 20, Rand Corp. (2014), *available at* http://tinyurl.com/mmf8j88 [hereinafter Rand Analysis].

[15] Urban Analysis at 1; Rand Analysis at 20.

[16] Urban Analysis at 4.

[17] Rand Analysis at 2.

[18] *See* 42 U.S.C. § 18011; Letter from Gary Cohen, Dir., Ctr. for Consumer Info. and Ins. Oversight, to Ins. Comm'rs (Nov. 14, 2013), *available at* http://tinyurl.com/lp79qpj.

[19] *See* Memorandum from Gary Cohen, Dir., Ctr. for Consumer Info. and Ins. Oversight Regarding Extended Transition to Affordable Care Act-Compliant Policies (Mar. 5, 2014), *available at* http://tinyurl.com/k5t5o27.

insured individuals onto the market for ACA-compliant plans. As to grandfathered plans, there is no guarantee that insurers will continue offering these plans, and enrollees in those plans may likewise be forced to find new coverage. In short, those who are presently insured on the federally-facilitated Exchanges, or who would need to rely on those Exchanges in the coming years, will have no good options if subsidies are eliminated.

This likely outcome is the result of an anticipated aspect of the statutory design. A key component of the ACA was a series of reforms to guarantee coverage regardless of preexisting conditions and to improve the quality of coverage on the individual market.[20] As Congress appreciated, guaranteeing coverage and improving the quality and comprehensiveness of insurance would – all else equal – greatly increase the cost of premiums. *See, e.g.*, Letter from Douglas W. Elmendorf, Dir., CBO, to the Honorable Evan Bayh, U.S. Senate, Attachment, at 4–7 (Nov. 30, 2009), *available at* http://tinyurl.com/oeman27 (predicting that insurance market reforms would, standing alone, cause premiums to rise substantially). Subsidies (together with other provisions) ensured that all else

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[20] These reforms included prohibiting discrimination against individuals with preexisting conditions, 42 U.S.C. § 300gg–3(a); prohibiting premium rating on the basis of health status, *id.* § 300gg(a); guaranteeing the issuance of coverage to any individual, *id.* § 300gg–1; requiring that health plans cover a range of "Essential Health Benefits," *id.* § 300gg–6(a); and establishing minimum actuarial values for given levels of coverage, *id.* §§ 18022(a)(3), (d).

would not be equal. Without them, Congress understood, premiums would rise significantly and affordable coverage would be out of reach for many.

HCA's patients (and millions of other Americans) on the federally-facilitated Exchanges will be affected by this case regardless of whether they had insurance coverage prior to the ACA. Not only will previously uninsured individuals once again be without coverage options, but the substantial share of HCA's federally-facilitated Exchange patients who *were* previously insured will likely not have access to any well-functioning insurance market as an "escape route." Congress, in expressly designing the ACA to "achieve near-universal coverage," 42 U.S.C. § 18091(2)(D), could not have intended to create a structure that would predictably cause the uninsured rate to *increase* in federally-facilitated Exchange states.

E. The ACA's "Shared Responsibility" Framework Is Functioning As Congress Intended.

Central to the ACA was a basic economic and political compromise: the key stakeholders in the country's health care system – "individuals, insurers, governments, hospitals, and employers" – would share the costs of achieving near-universal coverage, while the Act would, "at the same time, offset[] significant portions of those costs with new benefits to each group." *NFIB*, 132 S. Ct. at 2670 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting). This balance is beginning to work as Congress intended: HCA has faced major reimbursement cuts from the time the ACA was enacted, but beginning in 2014, it

is now seeing offsetting revenue gains as a result of newly insured patients on the federally-facilitated Exchanges.

In negotiations leading up to the ACA, hospitals agreed to accept, and Congress codified in the law, at least $155 billion in cuts to federal reimbursements hospitals otherwise would have received over ten years. *See* ACA §§ 2551, 3025, 3133, 3401.[21] The agreement to cuts of this nature was "part of a health overhaul that assumes coverage of 95 percent of the American people."[22]

The CMS Office of the Actuary has subsequently estimated the amount of these cuts to all providers as at least $283 billion over ten years.[23] For HCA, these ACA provisions have significantly reduced the reimbursements that would otherwise have been received from the Medicare program. Looking only at states with federally-facilitated Exchanges, the ACA has already cut revenues to HCA by approximately *$600 million* between 2010–2014. HCA Report at 12. Those substantial

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[21] John Reichard, *Biden Announces Deal With Hospitals to Cut Medicare, Medicaid Payments by $155 Billion*, CQ Healthbeat, July 8, 2009, *available at* http://tinyurl.com/lj8tba4.

[22] *Id.*

[23] *The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures*, Statement of Richard S. Foster, FSA, Chief Actuary, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs., Before the Subcomm. on Health of the H. Comm. on Energy and Commerce, 112th Cong. (2011), *available at* http://tinyurl.com/pfgzlqd.

decreases started on April 1, 2010, well before the ACA's insurance expansion began to take effect. Moreover, the ACA calls for continued, significant annual reimbursement cuts through at least 2019.

As Congress intended, however, these cuts are just beginning to be offset by increased revenues resulting from newly insured Exchange patients. HCA estimates that, in 2014, it had approximately $250 million in incremental revenue from treating previously uninsured patients who now have coverage through the federally-facilitated Exchanges. HCA Report at 12. Thus, through December 31, 2014, HCA has seen a cumulative net reduction in revenues of approximately $350 million as a result of the ACA for facilities operating in states with federally-facilitated Exchanges. In other words, HCA has recovered less than half of its reimbursement cuts in federally-facilitated Exchange states through increased coverage. Increased revenue through expanded insurance on these Exchanges is necessary for HCA to be able to "make up" this differential over the coming years. If those incremental revenue gains, underpinned by the availability of subsidized coverage, do not continue, HCA's losses from the ACA's provider cuts would not be offset as Congress intended.

In fact, if the subsidies are eliminated, the impact could be even worse. The calculation above reflects only the increased revenue from patients on the Exchanges who were previously uninsured. But as discussed, without subsidies on the federally-facilitated Exchanges, many previously insured Americans would likely lose access to affordable

coverage. If those individuals no longer pay for their care (like the overwhelming majority of HCA's uninsured patients), the net impact of the ACA's reimbursement cuts would be even greater.

This is the exact opposite of the "shared responsibility" framework Congress enacted. *NFIB*, 132 S. Ct. at 2670 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting). As the joint dissent in *NFIB* explained, hospitals accepted "reductions in the reimbursements [the government] pays to hospitals" under Medicare and Medicaid, but in return were to "benefit from the decrease in uncompensated care" that would come with adding to the ranks of the insured. *Id.* The legislative record confirms that this balanced approach was, in Congress's view, the reason "we can reduce our payments to hospitals in America, because the amount of uncompensated care they currently have will be dramatically reduced." 155 Cong. Rec. 29,303 (Dec. 3, 2009) (Sen. Ben Cardin).[24]

It could not have been Congress's intent to expose hospitals to mandatory cuts but make subsidized Exchange coverage optional. "Invalidating the key mechanisms for expanding

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[24] Congress understood that this balance was necessary not just economically but politically. As the then-Chairman of the Senate Finance Committee explained, "[w]hen President Clinton attempted health care reform," hospitals and insurers opposed it. This time, by contrast, there was a "deal" in which hospitals agreed to accept a decrease in reimbursements because "everybody [would have] health insurance." 155 Cong. Rec. 29,332 (Dec. 3, 2009) (Sen. Max Baucus).

insurance coverage . . . without invalidating the reductions in Medicare and Medicaid [reimbursements], distorts the ACA's design of 'shared responsibility.'" *NFIB*, 132 S. Ct. at 2672 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting). Petitioners' interpretation would "distort[] the ACA's design" in exactly that way. Whereas the *NFIB* joint dissent recognized that Congress intended the ACA's insurance-expanding provisions and its provider cuts to stand or fall together, Petitioners in effect ask this Court to "sever" the former while retaining the latter.

Moreover, the ACA's objective of reducing uncompensated care does not benefit only health care providers. Rather, the costs of treating the uninsured are ultimately shared by insured families and businesses that provide insurance to their employees (including HCA). A radical change to the availability of affordable coverage under the ACA could have negative effects on businesses and individuals throughout the economy, and at a minimum could produce considerable economic uncertainty.[25]

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[25] Consistent with the negative economic consequences of making coverage less affordable, not one business or business association, small or large, has filed a brief in support of Petitioners' attempt to eliminate subsidies from the federally-facilitated Exchanges.

II. The ACA Provides Subsidies To Residents Of States That Elect Not To Administer An Exchange.

HCA's experience shows that, because of the availability of subsidized coverage on the federally-facilitated Exchanges, the ACA is functioning as intended. Petitioners seek a radical change in this status quo, one that could jeopardize coverage for millions of Americans, risk destabilizing insurance markets, disrupt the "shared responsibility" framework of the ACA, and inject uncertainty into the economy. Basic tools of statutory construction refute Petitioners' interpretation, as HCA's data help confirm.

A. Petitioners' Interpretation Is Inconsistent With The Statutory Text.

The grant of premium subsidies to low- to moderate-income families is a critical element of the ACA, codified under the rubric of "Affordable Coverage Choices for All Americans." ACA tit. I, subtit. E. The statute, on its face, makes subsidies available to any "applicable taxpayer," a category defined only by income level, not state of residence. 26 U.S.C. §§ 36B(a), (c)(1). Thus, for any American with income between 100%–400% of the federal poverty level, "there shall be allowed as a credit" a premium subsidy. *Id.* § 36B(a).

In Petitioners' view, however, Congress made residents of every state eligible for a subsidy, only to then deny subsidies to every resident of certain states through the application of a formula for *calculating the amount* of the subsidy. Specifically,

because the amount of the subsidy is tied to the cost of a plan offered on an "Exchange established by the State," *id.* § 36B(b)(2)(A), Petitioners argue that the calculation works out to $0 for every resident of a federally-facilitated Exchange state.

Congress does not hide "elephants" in such "mouseholes." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). No member of Congress – not to mention the millions of Americans who have relied on the promise of subsidies and are now overwhelmingly satisfied with their coverage[26] – would have understood these five words buried in a formula as making the promise of affordable coverage illusory for large swathes of the population.

The text of the statute confirms what common sense suggests: the ACA's subsidy-calculation provision does not have the massive import Petitioners seek to give it. Rather, the ACA's definitions make clear that *every* "Exchange" is treated as "established under section 1311" – the section obligating states to establish Exchanges – even when the federal government is in fact operating the Exchange under section 1321. 42 U.S.C. § 300gg–91(d)(21). Section 1311 itself specifies that every Exchange is, by operation of law, "a governmental agency or nonprofit entity *that is established by a State*." 42 U.S.C. § 18031(d)(1) (emphasis added). And in directing HHS to operate

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[26] *See* Frank Newport, *Newly Insured Through Exchanges Give Coverage Good Marks*, GALLUP (Nov. 14, 2014), http://tinyurl.com/pjr57mh; Hamel et al., *supra* n.11.

"such Exchange," Congress confirmed that a federally-facilitated Exchange under section 1321 is still, for statutory purposes, an Exchange established by the state under section 1311. ACA § 1321, 42 U.S.C. § 18041(c)(1). Together, these provisions make clear that Congress used "Exchange established by the State" in § 36B as a statutory term of art, not as a roundabout way to deny affordable coverage to residents of states that decline to run their own Exchange.

Congress's use of "established by the state" as a term of art is confirmed throughout the ACA. For example, if the phrase excludes federally-facilitated Exchanges, those Exchanges would have no customers, because the only individuals "qualified" to buy coverage on an Exchange are those who "reside[] in the State that established the Exchange." 42 U.S.C. § 18032(f)(1)(A)(ii). Nor could a federally-facilitated Exchange offer any plans under Petitioners' approach. An Exchange can only offer plans that are "in the interests of qualified individuals," 42 U.S.C. § 18031(e)(1)(B), and Petitioners concede that under their interpretation, there are *no* "qualified individuals" in states with federally-facilitated Exchanges. Petitioners' Br. 48–49. If, on the other hand, one reads the statute as a coherent whole, including the ACA's provisions defining *every* Exchange as an "Exchange established by the State," these anomalies vanish and the Government's construction of § 36B makes perfect sense.

B. Petitioners' Interpretation Is Inconsistent With The Statutory Structure.

This Court has repeatedly stressed the importance of avoiding interpretations that would cause "the structure of the Act . . . [to] be compromised to a serious degree." *Maracich v. Spears*, 133 S. Ct. 2191, 2203 (2013). Rather, the Court strives for interpretations that make sense of a provision's "place in the overall statutory scheme." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (internal quotation marks and citation omitted). Here, however, Petitioners' interpretation would disrupt a statutory scheme whose provisions are uniquely "interdependent." *NFIB*, 132 S. Ct. at 2670 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting).

1. *Subsidies and the "Backup" Exchanges.* In enacting § 1321(c) to require HHS to run Exchanges if states do not, Congress obviously intended to accomplish *something*. *See Nw. Austin Mun. Util. Dist. No. 1 v. Holder*, 557 U.S. 193, 211 (2009) (it is "unlikely that Congress intended [a] provision to have such limited effect" that it would be "all but a nullity"). But Petitioners have no plausible explanation for what the point of § 1321(c) would be under their interpretation.

"Without the federal subsidies, individuals would lose the main incentive to purchase insurance inside the exchanges" and insurers would "be unwilling to offer insurance inside of exchanges." *NFIB*, 132 S. Ct. at 2674 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting). As a result, § 1321(c)

Exchanges without subsidies "would not operate as Congress intended and may not operate at all." *Id.* Moreover, as discussed above, even if plans did elect to continue participating in the Exchanges, their products would likely be out of reach for most, as premiums could soar in the absence of subsidies. *See supra* pp. 20–23.

It is no answer that Congress meant the "backup" Exchanges to do nothing more than provide a forum for "one-stop shopping," Petitioners' Br. 2, 37, since the plans offered at that "one-stop shop" would be unaffordable – if they exist at all. Nor is it any answer that Congress failed to consider the possibility that states would not establish their own Exchanges. Petitioners' Br. 43. This is not like Medicaid expansion. Congress fully understood "that some states might decline federal funding for the operation of a 'health benefit exchange,'" and so (unlike Medicaid) it "provided a backup scheme." *NFIB*, 132 S. Ct. at 2665 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting).[27]

The Court should reject Petitioners' strained interpretation of the statutory structure, under which Congress went to the trouble of establishing "a backup scheme" that could have little or no effect.

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[27] One opponent of the ACA in Congress specifically objected to the fact that a "Federal agency" would be "charged with" running backup Exchanges, and presciently predicted that the federal government would run the Exchanges in "up to 37" states that "may not set up the State-based exchange that the bill . . . calls for." 156 Cong. Rec. H2207 (daily ed. Mar. 22, 2010) (Rep. Michael Burgess).

2. *Subsidies and the ACA's Market Reforms.* As discussed above, HCA's data show that slightly more than half of its patients on the federally-facilitated Exchanges previously had insurance. But because of the ACA's reforms of the individual market, those who lose their coverage on the Exchanges will likely find it difficult to afford new coverage, whether or not they were previously insured. Congress took these dynamics into account when it offset its market reforms – which it knew would make premiums rise – with countervailing measures to bring premiums down, including subsidies. *See supra* pp. 22–23.

Under the ACA's interconnected statutory scheme, subsidized coverage was critical to enacting market reforms while keeping insurance affordable and premiums manageable. Indeed, the statutory text reflects Congress's concern with preventing its insurance market reforms from "destabiliz[ing] the individual market." 42 U.S.C. § 300gg–18(b)(1)(A)(ii); *see also id.* § 18061(c)(1)(A) (measures to "help stabilize premiums for coverage in the individual market in a State" at risk for "adverse selection"). Rather than treat the ACA as a "coherent regulatory scheme," *Brown & Williamson Tobacco Corp.*, 529 U.S. at 133, Petitioners conclude that Congress has paired *mandatory* market reforms with *contingent* subsidies. The result is to subvert the statutory structure and invite the very destabilization Congress sought to prevent.

3. *Subsidies and Federalism.* The disruptions that withdrawal of subsidies could cause also undermine Petitioners' theory that Congress sought

to cajole states to operate Exchanges through "the incentive of subsidies." Petitioners' Br. 14. Their version of the ACA is a threat, not an incentive. If states elect not to run their own Exchange, they would not just lose a new benefit; they could experience severe repercussions in their preexisting insurance markets.

These draconian consequences cannot be squared with the statute's approach to federalism, as made apparent by the statutory language itself. Rather than threatening states with disaster if they did not follow Congress's preferred course, Congress offered them "state flexibility in operation and enforcement of Exchanges." 42 U.S.C. § 18041. And with this "flexibility," states are free to "elect[]" whether or not to run their own Exchange. *Id.* § 18041(c)(1). Petitioners cannot square the federalism-promoting language of ACA § 1321 with their interpretation of 26 U.S.C. § 36B as a potent threat.

4. *Subsidies and the Economics of "Shared Responsibility."* Finally, the structural logic of the ACA was to spread the costs and the benefits of achieving universal coverage throughout the health care system. *See NFIB*, 132 S. Ct. at 2670 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting). Thus, hospitals like HCA were intended to lose significant federal reimbursements, but to have those cuts offset by new revenues resulting from expanded insurance. *Supra* pp. 23–27. Petitioners' interpretation would uncouple costs from benefits, undermining the "shared responsibility" framework of the statute in a manner Congress could not have intended.

C. Petitioners' Interpretation Is Inconsistent With The Statutory Purpose.

Petitioners' interpretation cannot be accepted for the additional reason that it would "undermine in a substantial way the [statute's] purpose." *Maracich*, 133 S. Ct. at 2200. There is no need to resort to legislative history to divine the fundamental legislative purpose of the ACA, because the statute makes it plain: "achiev[ing] near-universal coverage." 42 U.S.C. § 18091(2)(D). At the lowest income levels, Congress relied on expanded Medicaid to achieve this purpose, and at higher levels Congress relied on employers. But in order to ensure "affordable coverage choices for *all* Americans," ACA tit. I, subtit. E (emphasis added), subsidized Exchange coverage for everyone with an income between 100%–400% of the federal poverty level was necessary. Petitioners' interpretation would, in many states, close this door to coverage for millions.

Petitioners' interpretation would likewise thwart many of the congressional objectives underlying the overarching goal of universal coverage. Congress expressed concern with the billions of dollars in uncompensated care being consumed, and the "free riding" that caused insured families' premiums to be $1,000 higher per month. *Supra* pp. 8–9. Congress sought to reduce ER usage and encourage patients to use more efficient and appropriate forms of care. *Supra* pp. 12–14. And it sought to correct the imbalance in women's ability to obtain access to needed care. *Supra* at 17–18.

HCA's data show that the ACA, as implemented, is already helping to achieve these

purposes. But if subsidies are eliminated from the federally-facilitated Exchanges, the aims of the ACA would be undermined. The vast majority of those who would be unable to afford coverage on an Exchange without subsidies – or any alternative form of coverage – would likely become uninsured. Nine out of 10 of them would likely again pay nothing for services provided at health care facilities. The costs of their care would again be paid by employers and insured families. The reductions in ER usage would likely be reversed. And women, who make up a disproportionate percentage of HCA's Exchange patients, would again face disproportionate disadvantages in accessing preventive care, diagnostic care, and needed treatment. Congress could not plausibly have meant to sacrifice its fundamental goal of universal coverage, and many related objectives, just to punish states that use their "flexibility" to "elect" not to administer their own Exchange.

D. Petitioners' Interpretation Yields Absurd Consequences.

A careful reading of the entire statutory text leads to the conclusion that Congress used the phrase "Exchange established by the state" as a statutory term of art encompassing the federally-facilitated Exchange within a state. Consideration of the statutory structure and the ACA's basic purposes supports that interpretation.

But even if the text could only be read as Petitioners contend, this would be one of the rare cases in which a statute must be read to avoid an "absurd" result. *Green v. Bock Laundry Mach. Co.*,

490 U.S. 504, 527 (1989) (Scalia, J., concurring in the judgment); *see also Public Citizen v. U.S. Dep't. of Justice*, 491 U.S. 440, 471 (1989) (Kennedy, J., concurring in the judgment) (Court may look past clear text "where it is quite impossible that Congress could have intended the result"). At a minimum, this case triggers "the precept that 'interpretations of a statute which would produce absurd results are to be avoided if alternative interpretations consistent with the legislative purpose are available.'" *Lawson v. FMR LLC*, 134 S. Ct. 1158, 1183 (2014) (Sotomayor, J., joined by Kennedy & Alito, JJ., dissenting) (quoting *Griffin v. Oceanic Contractors, Inc.*, 458 U.S. 564, 575 (1982)).

Without subsidies, the goal of near-universal coverage would be impossible. Not only would many newly uninsured Americans be stripped of coverage, but the likely effect of the ACA as interpreted by Petitioners would be an overall *increase* in the uninsured in federally-facilitated Exchange states relative to a pre-ACA baseline. *Supra* pp. 18–23. It cannot be that Congress's "comprehensive national plan to provide universal health insurance coverage," *NFIB*, 132 S. Ct. at 2606 (op. of Roberts, C.J., joined by Breyer & Kagan, JJ.), was actually a plan to take coverage away and destabilize insurance markets. Indeed, "[i]t defies logic to think that Congress would disregard [these] real-world consequences." *Northwest, Inc. v. Ginsberg*, 134 S. Ct. 1422, 1430 (2014).

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The fundamental question in this case is whether the ACA is in fact "a comprehensive national plan to provide universal health insurance coverage," *NFIB*, 132 S. Ct. at 2606 (2012) (op. of Roberts, C.J., joined by Breyer & Kagan, JJ.), or instead contains a trap door through which millions of Americans may fall.

Every tool of statutory interpretation indicates that Congress intended the former. With subsidies available on the federally-facilitated Exchanges, the newly insured are able to take personal responsibility for their care, emergency room usage is dropping, women are gaining access to needed care, and the costs and benefits of expanding coverage are being shared throughout the health care system. Without the subsidies, an otherwise coherent regulatory scheme may come apart at the seams: the newly insured could lose coverage, the positive trends in the delivery of care noted above could be reversed, the economic logic of the ACA could be disrupted, the federally-facilitated Exchanges could slide into dysfunction, and even the previously insured could lack access to a viable alternative market.

This Court should follow the interpretation that makes sense of the ACA's interconnected provisions. That interpretation is that subsidies are available to every "applicable taxpayer," without regard to whether his or her state has elected to run its own Exchange.

CONCLUSION

For the foregoing reasons, as well as the reasons set forth in Respondents' brief, the decision of the court of appeals should be affirmed.

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